Request for Proposals: OHB03-3

Administrative Services For Dental Benefit Plans
Issued July 8, 2003

Addendum One

July 18, 2003

Preface

This Addendum is issued to provide all potential offerors with definitive guidance, to the extent that is possible, on the issues raised at the Offerors' Conference held on July 18, 2003. This addendum pertains to the specific RFP listed in the heading. Separate, similar addenda will be issued addressing the specific issues raised at the Offeror's Conference for the three companion RFPs discussed at the Offeror's Conference on July 18. As announced at that conference, only these answers in writing can be relied upon in preparing an offer in response to this RFP.

Please note: Supplemental Addendums (numbered sequentially: TWO, THREE, etc) will be issued and posted to the Department's web site (www.dhrm.state.us.va) if the need arises to communicate additional information to potential Offerors. It is recommended that each interested firm check the web site regularly until the date that proposals are due and contracts awarded.

NOTE: The last page to this Addendum contains a list of all firms represented at the Offerors' conference for this RFP.

Corrections

1. Page one **"Note "** section, change Code of Virginia 11-35.1 to Code of Virginia 2.2-4343.1
2. Section 1.3 – In last paragraph, replace "dental" with "prescription Drug"
3. Section 3.6.1 – Replace "4.1.5" with "4.1.6"
4. Section 4.1.1 – Add "and 4.1.7" to the end of the sentence
5. Section 8.2.3 - second paragraph change "labor" to Labor
6. Section 8.9 - change "code section 2.1-377 to code section 2.2-4343.1

Additions:

1) **ADD:** Section 3.5 – SCHEDULE OF LIQUIDATED DAMAGES

The third standard "Eligibility Files not picked up within 7 days of transfer" should read, " Eligibility Files not picked up and loaded to Contractor's eligibility files with 7 days of transfer".

2) ADD: Attachment 2 – Questionnaire General #7

#7. Please provide a copy of your business plan for complying with the HIPPA Security Requirements.

Questions and Answers:

1. Is the Department interested in one sole carrier, or is there a possibility of multiple carriers?

One

2. Which municipalities are parts of Local Choice? Which are parts of COVA?

TLC groups are local political subdivisions and may include towns, cities, counties, local authorities, etc. State employee eligibles are full time classified employees of the state and universities. **There are no municipal employees covered by the State plan.**

3. Will the dental plan be voluntary (i.e., will members elect whether to accept this coverage, or, will it be included with any member who requests medical coverage?)

Currently each plan offered has a basic dental component and enrollees have the option of buying expanded coverage. See Employee Handbook reference in question 36.

4. We noticed that references to retirees include the qualifier, "not eligible for Medicare." Are retirees eligible for Medicare excluded from enrolling in the dental plan? **Yes**.

5. Will a dental DHMO be considered? **Yes.**

6. How many potential covered lives (employees, retirees, COBRA, and dependents of these categories)?

N/A. See CD for enrollee census.

7. How many enrollees have elected to participate in the Expanded Dental programs for level 3 & 4 dental services in each of the health plans?

For the plan year ended June 30, 2003, approximately 53% of state enrollees elected expanded coverage.

8. Section 2.3.2 - Please clarify the requirement that a dental network should encompass at least 50% of the professional providers in active practice within each city and county of the commonwealth--is this a requirement or a preferred goal.

This is the preferred goal. Each network will be looked at individually in locations where 50% of the available providers are not in the proposed network.

9. Section 2.3.3 states "directories must be furnished to all group administrators". Will having this information available on our website meet this requirement? If not, can a PDF file be e-mailed? How often would we be required to provide directories?

Yes – A web directory is requested and should be updated monthly.

10. Section 2.6.2.b -- Would the Department want Contractor to print and distribute a handbook, if requested to develop one? **Yes.**

11. Section 2.4, # 11 – How are initial claims financed? A) Although the Administrator will not have any risk under a self-insured plan, will the Administrator be responsible to maintain sufficient funds to provide for the cash benefits payable under the plan until the claims can be reimbursed by Virginia? In other words will the Administrator be required to advance claims payments on behalf of the State until reimbursements can be made? B) If so for what period of time and what are claims averaging for this period of time for each of the levels of dental services?

It is not the intent of the Department to have a Contractor fund claims payments. This will be addressed during negotiations.

12. Section 2.6, #3 – requests the Contractor to "provide a legal defense against all claims arising out of this contract." Could this be modified to state something to the effect of "Provide a legal defense against all claims arising from Contractor error, omission or negligence in the administration of this contract. Contractor shall not be expected to provide legal defense for claims resulting from actions of the Commonwealth, other vendors, members, non-network providers or other third parties?"

State any demurrals with recommended wording in your proposal.

13. Section 2.6, #4. Contractor is expected to "hold enrollees and covered dependents harmless with respect to services covered under this contract when such services are furnished by participating providers." Is this referring to suits brought against enrollees or covered dependents for balance billing? Is there any other type of situation that has occurred that would require indemnification for enrollees or covered dependents?

Balance billing was the intent of this section.

13. Introduction, Page 7, Section 2.6.2.a. Please expand on what type of assistance the Contractor may be expected to provide for the dental plan and other "benefit plans not covered by this contract."

Contractor will provide the technical expertise regarding their benefits in communications preparation.

14. What types of printed materials will be mailed to members?

ASO Medical Contractor will mail ID cards. All Contractors will be responsible for their product specific information if not adaptable to the Employee Handbook and other program wide communications.

15. Is the Contractor expected to supply postage for all mailings? **Yes.**

16. Do you anticipate needing marketing materials for the health fairs (handouts, signs, giveaway items)? Do you anticipate a direct mail campaign? **No**

17. Are performance guarantees account specific or book of business? **Account specific**.

18. Section 3.2 – This paragraph references pickup of an electronic eligibility file. Will this file be available electronically? Or, are we to take this reference literally?

Yes. State eligibility updates will be made electronically using HIPAA 834 format.

19. Is the Contractor expected to recommend premiums for the plan?

See Paragraph 4.1.7. The rate to be proposed is for their specific product(s).

20. Re Section 6.5.1., page 17. Is it the Department's preference to pay for start up costs separate and not include those expenses in the pm/pm administration fee? **Yes**

21. Section 6.2 Legally Correct Description of Benefits. It is noted COVA Care benefits are slightly different than those offered under TLC. Is it the desire of the Department that the benefit designs match? **Yes, normally but may vary due to business requirements**

22. Please provide a copy of the Commonwealth of Virginia's Vendor's Manual at the Pre-proposal Conference. **See paragraph 7.1.**

23. Section 8.2.2 addresses open enrollment. Would we be asked to staff open enrollment meetings? If so, how many meetings would we be required to attend?

Yes, approximately 10 for each program.

24. Page 26 - 8.4 Payments and Interest, 8.4.4 (This section address Retroactive Adjustments) - If retroactive cancellations are made, is the carrier to pursue refunds from the members and for what dollar amount?

Yes. From member and/or provider for payments made for ineligible benefits.

25. Can the State provide a listing of dentists used by COV/TLC employees so that we can prepare a disruption analysis of these providers against our proposed dental networks?

The current dental contractor is Anthem. Go to their web site from the DHRM web site and information is provided on providers currently available to the Department's covered eligibles.

26. May the large reports such as Small Businesses and Businesses Owned by Women and Minorities be submitted only on CD, rather than in hard copy? **YES**

27. Are the MBE requirements voluntary or mandatory? **Voluntary**

28. Is the % Total Company Expenditures for goods and services on page 38 the same as the % Total Contract Expenditures for Goods and Services column on pages 39, 41 and 43? **Yes.**

29. Does the Commonwealth have an "Approved Vendor Listing" or can we use our current vendors from other contracts? **May use current vendors**.

30. How will the eligibility and premium billing be handled for the COBRA and Retiree populations?

The Department will provide premium eligibility and collections to the carve-out Contractors. The Department will reimburse all ASO Contractors for claims payments.

31. Appendix 9: TLC Program Administration - (a) Are the TLC groups billed directly by the carrier and are the payments for the TLC groups collected by the carrier separately from the Commonwealth's employees claims and ASO Fees? (b) Are the TLC groups individually enrolled and billed on a fixed premium per enrollee basis (i.e. on a set amount per single, per family etc.)?

The ASO medical Contractor bills TLC groups for the entire premiums. Carve-out ASO Contractors need not be concerned regarding the premium billing process.

32. Appendix 9 - B. Enrollment by employees of TLC Member Groups - We can provide the toll free customer service line to assist with questions on the benefits, however we thought the plan specific materials would be provided and distributed by the group. Will we be required to maintain a supply in customer service and distribute per request or will they be contacting M&B to distribute the requested materials?

The groups will distribute materials. However, in order to provide excellent customer service, it may be advisable to have a supply for distribution upon request.

33. Please clarify the processes to be used for updating eligibility and billing. Appendix 8 and Appendix 9 indicate that for State employees the carrier will access a Department website to pick-up the eligibility and bill the Department. For Local Choice the document seems to indicate that the carrier would receive eligibility from and bill each municipality. Is this correct?

The ASO medical Contractor(s) will bill each group and update eligibility. The Department will then see that all Contractors receive this updated eligibility.

34. Would the eligibility data be provided in a uniform format, or would the format differ by municipality? **Uniform**

35. In the Appendix 2, claim information, dental "charges" are shown. Is the net paid claims amount available? **NO**

36. It is understood that there are two dental plans through DHRM. One through COVA Care and one through TLC. Please describe the current dental plans in detail. (Plan design, who can take each plan, etc.)

The complete information provided is correct as reflected in the COVA Care Member Handbook dated July 2003, pages 15--16. "Prosthetic and complex restorative services" and "Orthodontic services" are also addressed in the same document on pages 82--83. This can be accessed at the Department of Human Resource Management's Web site at: www.dhrm.state.va.us/hbenefits/covacare.html. Click on Member Handbook.

The Department typically offers a basic dental benefit as a part of the health plan and an optional dental buy-up provision (the full cost of which is borne by the participant). However, we encourage bidders/Offerors to present other dental plan structures that might provide reasonable benefit levels and innovative cost-saving provisions.

There are no municipal employees covered by the State plan.

37. Do you have a list of limitations or exclusions? If not, can you receive a list from the current health contractors that they used for administered the dental claims?

See Member Handbook referenced under #36 above.

38. Attachment 1 - Schedule of Benefits does not mention waiting periods; however, online, there is mention of a 12-month wait for orthodontic. Please clarify the waiting periods for orthodontic services. Are there any other waiting periods under the proposed plans?

See Member Handbook referenced under #36 above.

39. Can you elaborate on the 25% penalty applied to eligible services performed by a non-network provider? Does this mean that the coinsurance is 25% higher when a non-network provider performs services?

Out of network 25% penalty only applies to the medical and MISA benefits.

40. Orthodontic coverage is not eligible during the first 12 months of coverage unless the member had previous orthodontic coverage. The number of months of previous coverage will count towards the 12-month waiting period and benefits paid count against the lifetime maximum. How are insurers notified if a member is subject to the waiting period and/or how many months of previous coverage and benefits paid?

Contractor will be provided file of current enrollees having expanded benefits at startup of new contract, if relevant.

41. At what percentile are out-of-network benefits reimbursed?

For dental, at same percentile as in network benefits or offeror may suggest a difference.

42. Do you have a written description of the covered services under each of the four levels of dental coverage? Do you have a list of ADA codes that are covered? If not, can you receive a list from the current health contractors that they use for administering the dental claims?

See Member Handbook referenced under #36 above. Offeror should provide in their proposal a list of services that hey are offering.

43. Would the Department consider alternative dental plan designs? **Yes**

44. It appears for in-network participating providers providing Level 1 care 100% of R&C for procedures are covered; for Level 2 80% of R&C are covered. Are any benefits paid for non-PPO participating providers?

Same levels of benefits are paid for participating and non-network providers.

45. Are there age limitations for orthodontics (i.e., through age 18)? Are accidental dental injuries covered under the medical plans?

See Member Handbook referenced under #36 above.

46. Attachment 2 is not labeled as such. Please confirm that it starts with the page that is titled "COMMONWEALTH OF VIRGINIA EMPLOYEE HEALTH BENEFITS PROGRAM PROCUREMENT Statewide Self-Funded Medical Surgical Questionnaire" for the medical/surgical RFP and correspondingly in the other RFPs.

YES, that is correct.

47. At what payment level (percentile) have dental claims been reimbursed over the last two years? Are there regional differences in the fee allowances or is a statewide schedule used? Are the allowances different for dental specialists (e.g. oral surgeons or orthodontists) than general dentists? If so, what is the payment (percentile) level? How is the payment level *for* out-of-state claims determined?

That information is not available. We are interested in knowing the results of your proposed plan whose benefits may/may not mirror the current programs.

48. Can you provide a copy of the current utilization and discount > reporting for the dental program?

NO

49. Section V.Q.2. of the Questionnaire asks for a description of claim cost control features in a chart format. Is there a specific definition of "Plan Provision Savings"? Does this include deductible savings, coinsurance savings, ineligible claims denied, professional review savings, non-covered services, claims over the plan maximum, or processing policy savings? If not, should these be included in lines (e) or (f) as general network plan savings?

Includes deductible savings, coinsurance savings and claims over plan maximum.

50. Is there a list of dental procedure codes covered by Dental plan for the past two years and an indicator of which class of services each code belongs to?

NO, but an indication of the covered services by class can be found in the handbook.

51. In Section III. of the Questionnaire, Q.9 is missing. Was there a question or is this an inadvertent question number? **TYPO MISSED IN PROOFING**

52. Can dental claims experience (monthly claims amount, monthly claims count, and members per month) be provided?

The annual charge and enrollment data is included in the CD. Payment data will not be provided. The department will analyze the payment results obtained by your plan.

53. Can you provide documents entitled “OHB03-3 Attachments” electronically in Word format, particularly Attachment 2 since it contains the dental questionnaire and other charts.

Available on the CD picked up by each firm.

54. I am unable to determine the existing administrative fee structure that the Commonwealth has with the incumbent service provider.

It was not provided. However, current contractors used similar Schedule 2 schedules to provide their administrative pricing.

55. Should network access fees be bid separately from the administrative fee? Should the fees be bid per member/per month?

See Schedule 2.1 of Attachment 2. Network access fees are an identified component. Per member and per contract pricing is required as directed by the instructions and schedules.

56. Schedule 2-8, 1.a. and page 13, Question 1 of the Dental Questionnaire asks us to indicate what type of plan we are proposing. Is it acceptable to bid an Indemnity R&C with an open nationwide PPO option? **Yes**

57. Page 13, Question 1 of the Dental Questionnaire. Does Participating Provider (PAR) refer to a closed PPO – meaning there are no benefits payable outside the network?

NO. Generally it refers to a wide network whose participants agree to an allowable charge and do not balance bill any difference beyond applicable deductibles and/or co-pays.

58. Page 13, Question 2.b. We use different R&C percentiles for the different plans we administer based on their preference. We use 50% for our plan for federal members. However, for the plan we administer for the State of Texas we are required to use 90%. What is the Department's preference for the R&C percentile?

We ask that you propose the percentile that you think would best meet the Department's needs.

59. Can you provide estimates of claim volume or call volume? **See CD data.**

60. Schedule 2-1 – 11b. Are the dates in the first column to read 1/10/03 – 12/31/03 (now reads 2002)?

No, the column should show your results for the last completed calendar year.

61. Schedule 2-2, paragraph 4. Is the experience data included on the CD? If not, where is this data found? **Yes**

Firms Represented at the Mandatory Offerors Conference

10:00AM July 18, 2003

Anthem
BMS Consulting Inc. (Providence Inc.)
Cigna Healthcare
Delta Dental Plan of Virginia
Domion Dental Services, Inc.
Harrington
HealthPlan Holdings, Inc.
Kaiser Foundation Health Plan of The Mid-Atlantic States, Inc.
Providence Healthcare
Southern Health
United Concordia
United Healthcare of the Mid-Atlantic